Franchise Tax Board

ANALYSIS OF AMENDED BILL

Author: Not indicated | Analyst: Anne Mazur | Bill Number: ABX1 2

Related Bills: See Legislative History | Telephone: 845-5404 | Amended Date: November 8, 2007

Attorney: Patrick Kusiak | Sponsor:

SUBJECT:	Enforcement of Individual Health Care Mandate/Health Care Premium Refundable Credit/Health Savings Account Deduction Conformity/ Require Employers To Establish Section 125, Cafeteria Plans

SUMMARY

This bill, which would be known as the California Health Care Security and Cost Reduction Act, would do the following:

- Beginning July 1, 2010, require each California resident to maintain at least the minimum health care coverage (individual mandate).
- Permit the Secretary of California Health and Human Services (CHHS) to enter into an agreement with the Franchise Tax Board (FTB) to recoup any state funds advanced for health care coverage on behalf of noncompliant individuals.
- Beginning with taxable year 2010, allow the same deduction on California personal income tax returns for contributions to a Health Savings Account (HSA) as is allowed on the federal personal income tax return for the taxable year.
- State the intent of the Legislature to enact a refundable and advanceable income tax credit based on the amount of health care premiums paid.
- Beginning January 1, 2010, require certain employers to set up a cafeteria plan under Internal Revenue Code (IRC) section 125 (125 plan mandate).

This bill would make other changes to several California Codes related to the health care program, including establishing the California Health Trust Fund to provide health care coverage and pay program expenses. Discussion in this analysis is limited to those provisions of the bill that affect the FTB.

SUMMARY OF AMENDMENTS

The November 8, 2007, amendments deleted legislative intent language to enact comprehensive health care reform and added provisions that would carry out such reform, including but not limited to establishing an individual mandate, health insurance market and health care provider reforms, encouraging wellness, expanding subsidized programs, and stating intent regarding implementation and funding.

This is the department's first analysis of this bill.

Board Position:			Department Director	Date
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PURPOSE OF THE BILL

It appears the purpose of this bill is to provide universal health care for California residents.

EFFECTIVE/OPERATIVE DATE

If enacted during the special session, this bill would be effective on the 91st day after adjournment of this special session. The bill provides specific operative dates for the various provisions. Such operative dates are discussed below for the provisions that would impact FTB. Generally, however, the bill specifies that its provisions would be operative upon the date that the Director of Finance determines and informs the Secretary of State that there are sufficient state resources to implement those provisions.[1]

POSITION

Pending.

Summary of Suggested Amendments

Language is provided to correct technical errors with respect to HSA conformity operative dates.

ECONOMIC IMPACT

To the extent that the individual mandate encourages taxpayers to participate in section 125 plans (described below) or other tax-favored methods to purchase health insurance, there would be a reduction in personal income tax revenue. The amount of tax reduction resulting from this increased use of tax-favored expenditures depends on the estimated behavioral responses to the provisions of this bill. In addition, the tax reduction amounts are secondary to the expenditure and social impacts of this bill. To date, staff has not determined the behavioral responses that are estimated to occur under the provisions of this bill. Furthermore, staff understands that Jon Gruber,[2] who has developed the model to simulate the primary impacts of this proposal, will be developing his own estimates of these secondary impacts. As such, and because the impacts that department staff would be estimating are secondary, a revenue estimate will not be produced for this bill, except as provided for the HSA provision.

ENFORCEMENT OF THE INDIVIDUAL MANDATE

[1] The bill would state the Legislature's intent to fund the provisions of the bill in part by fees paid by employers not making health care expenditures for employees in specified amounts. The U.S. Court of Appeals for the 4th Circuit in *Retail Industry Leaders Association v. Fielder* (2007) 475 F.3d 180, ruled that Maryland's Fair Share Health Care Fund Act (Act) is preempted by ERISA (federal Employee Retirement Income Security Act Of 1974) because the Act directly regulates employers' provision of health care benefits, and therefore has a "connection with" covered employers' ERISA plans. More recently, on December 26, 2007, in *Golden Gate Restaurant Association v. City and County of San Francisco,* No. C 06-06997 JSW, 2007 U.S. Dist. LEXIS 94112 (N.D. Cal), a federal district court struck down a universal health care mandate for San Francisco on similar grounds. Although the effects of these decisions on the applicable laws of states, including California, is unknown, similar mandates involving covered ERISA plans may also be preempted by ERISA.

[2] Professor of Economics at the Massachusetts Institute of Technology.

EFFECTIVE/OPERATIVE DATE

If enacted during the special session, this bill would be effective on the 91st day after adjournment of this special session. The bill indicates that this provision would be specifically operative beginning on or after July 1, 2010; however, the bill also expressly states that implementation of this provision is contingent on the appropriation of funds for this purpose in the annual Budget Act or other legislation.

ANALYSIS

FEDERAL/STATE LAW

The federal Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 and among other things, establishes certain requirements that must be followed in the dissemination and distribution of health care related data. The provisions of HIPAA include specified guidelines for the transfer, storage, use, and destruction of personal health information, which includes premium payment data.

Under current state law, any fines, fees, penalties, forfeitures, restitution orders, or fines, or any other amounts imposed by a superior or municipal court in California that is delinquent for 90 days or more, can be referred to FTB for collection. After issuing a preliminary notice to the debtor, FTB is authorized to collect the debts referred by the courts in the same manner as authorized for collection of a delinquent personal income tax liability. FTB's costs attributable to this collection program are reimbursed through the amount FTB collects for the program, not to exceed 15%. In general, the county or state fund originally owed the debt receives the net collections after reduction by the amount of FTB's departmental costs.

FTB is responsible for the collection of delinquent vehicle registration fees assessed by the Department of Motor Vehicles (DMV). DMV retains management responsibility for all accounts assigned to FTB for collection. After issuance of a notice and demand to the debtor, FTB is authorized to collect the debts assigned by DMV in the same manner as authorized for collection of a delinquent personal income tax liability. FTB is reimbursed costs of collection based on a percentage of the amount of revenue realized.

The Department of Industrial Relations (DIR) may refer cases to FTB for collection that consist of delinquent fees, wages, employers' assessments, penalties, costs, and interest. After issuance of a notice and demand to the debtor, FTB is authorized to collect the debts referred by DIR in the same manner as authorized for collection of a delinquent personal income tax liability. FTB is reimbursed for actual costs of collections, depending on the debt type.

Current state law authorizes FTB to use administrative collection tools in order to collect delinquent tax and non-tax debt liabilities. Collection actions include, but are not limited to, attaching bank accounts, garnishing wages, or filing a Notice of State Tax Lien with the county recorder.

Current state law prohibits the disclosure of any taxpayer information, except as specifically authorized by statute. California law permits FTB to release individual tax return information to

specific state agencies. Agencies must have a specific reason for requesting the information, including investigating items of income disclosed on any return or report, verifying eligibility for public assistance, locating absent parents to collect child support, or locating abducted children. For some agencies, only limited information may be released, such as the taxpayer's social security number and address.

THIS BILL

This bill would, beginning July 1, 2010, require every California resident[3] to be enrolled in and maintain at least minimum health care coverage, as defined. For purposes of enforcing the individual mandate, this bill would require the Secretary of CHHS to do the following:

- Establish methods by which individuals who have not obtained health care coverage to be informed of the methods available to obtain affordable coverage through public programs, the statewide purchasing pool established under this bill to be administered by the Managed Risk Medical Insurance Board (MRMIB),[4] and commercial coverage.
- Establish methods to ensure that uninsured individuals obtain the minimum required coverage, including authorizing the Secretary to pay the cost of health care coverage on behalf of an uninsured individual,
- Establish methods by which funds advanced for coverage may be recouped by the state from individuals for whom coverage is purchased.

This bill authorizes the Secretary of CHHS to enter into an agreement with FTB to use its civil authority and procedures in compliance with notice and other due process requirements imposed by law to collect funds owed to the state that were advanced on behalf of uninsured individuals.

Additionally, the bill would require that to the extent possible, existing reporting processes employed throughout the state to report on the employment and tax status of individuals and other existing mechanisms are to be used to implement the enforcement of the individual mandate. FTB, Employment Development Department (EDD), DMV, and other appropriate state agencies are required to cooperate with the Secretary of CHHS and other responsible entities in undertaking these activities and implementing these provisions of this bill.

IMPLEMENTATION CONSIDERATIONS

[3] The bill would define "California resident" as an individual who is a resident as defined by a specified Government Code section or is physically present in the state, having entered with an employment commitment or to obtain employment, regardless of whether employed at the time the individual applies or is accepted for health care coverage. The Government Code generally determines residency as "the place where one remains when not called elsewhere for labor or other special or temporary purpose, and to which he or she returns in seasons of repose."

[4] The purchasing pool would be officially known as the "Health Care Security and Cost Reduction Program" established by this bill.

The department has identified the following implementation concerns. Department staff is available to work with the author's office to resolve these and other concerns that may be identified.

1. Although the bill permits the Secretary of CHHS to enter into an agreement with FTB for the collection of the unpaid health care premiums, the bill lacks authorization for FTB to use its civil authorities and compliance procedures for the collection of these debts as if they were tax debts. Specific statutory authorization is required to enable FTB to use its administrative collection tools and information sources for this purpose.
2. The bill is silent regarding the author's intent relating to the payment priority of debts. FTB collects several different types of debts, the priority for payment of which is established by statute. Clarification is needed to determine where health care coverage debts would fall in relation to general fund debts collected by FTB.
3. This bill requires the utilization of existing employment and tax data processes to administer the mandate, but lacks express authorization for FTB to provide tax data to CHHS for non-tax related purposes. An express exception to current disclosure restrictions relating to tax data is necessary to enable FTB to implement this provision. The exception should also expressly exclude any federal tax data maintained in FTB's records to preserve and comply with existing disclosure agreements and requirements related to federal tax data.
4. With an implementation date of the mandate of July 1, 2010, FTB anticipates referrals from CHHS for collection of unpaid premiums would be expected to occur within six months of that date. In light of the budget and approval process for new information technology and procurement, FTB does not believe successful implementation of an automated collection system and start up of a new collection workload could be achieved within this timeframe. This situation could result in delay of the start up time for the individual mandate.
5. The bill needs statutory direction on how the Legislature intends FTB to handle special circumstances for health care accounts relating to bankruptcy claims, decedent claims, or lien processing to prevent disputes between FTB, the client agency, and health care recipients.
6. The health care data that FTB would receive for the enforcement of the individual mandate consists of qualified health care data that is subject to HIPAA requirements related to the handling, storage, transmission, and use of this type of sensitive data. If FTB is determined to be bound by HIPAA, to the extent that existing systems and processes related to data security and transmission of tax data are inadequate in meeting the HIPAA requirements, additional costs would be incurred to develop a compliant system and program. The "Fiscal Impact" estimate below includes estimates of these additional costs.

LEGISLATIVE HISTORY

ABX1 1 (Nunez, 2007/2008) would enact the California Health Care Reform and Cost Control Act, which would create the California Cooperative Health Insurance Purchasing Program (CalCHIPP) to serve as a health care purchasing pool and make other changes to health care related provisions of several California Codes. It would require every individual in this state to maintain a minimum policy of health care coverage for himself or herself and his or her dependents, subject to certain exceptions.
It would state the intent to finance the new programs through contributions from various sources, including payments by acute care hospitals and employers, and by increasing the taxes on cigarettes and other tobacco products. The bill is currently in the Senate Health Committee.

AB 8 (Nunez, 2007/2008) would have created CalCHIPP to serve as a health care purchasing pool for employers and make other changes to health care related provisions of several California Codes. It would require employers to make health care expenditures or elect to pay an in-lieu fee to a specified fund. It would also require employers to set up a cafeteria plan under IRC section 125. The bill was vetoed by Governor Schwarzenegger. See attached veto message in Appendix 1.

SB 48 (Perata, 2007/2008), prior to the June 25, 2007, amendment would have established the California Health Care Coverage and Cost Control Act, which would require every individual with income subject to the Personal Income Tax to maintain a minimum policy of health care beginning January 1, 2011. The bill would have also permitted employers to elect to pay a fee in lieu of making health care expenditures and mandate certain employers to adopt and maintain an IRC section 125 plan. The bill was held in the Assembly Appropriations Committee.

SB 840 (Kuehl, et al., 2007/2008) would create the California Health Insurance System that would provide health care benefits to all individuals in the state. It would also create the California Health Insurance Premium Commission. FTB's Executive Officer would be required to be a member of the commission. This bill was held in the Assembly Appropriations Committee.

SB 840 (Kuehl, 2005/2006) would have established the California Health Insurance System and California Health Insurance Premium Commission. FTB's Executive Officer would be required to be a member of the commission. The bill was vetoed by Governor Schwarzenegger. See attached veto message in Appendix II.

AB 1952 (Nation, 2005/2006) would have established the California Essential Health Benefits Program and require FTB to distribute information regarding newly mandated health care coverage requirements. This bill was held in the Assembly Appropriations Committee.

AB 1528 (Cohn, et al., Stats. 2003, Ch. 702) contained provisions stricken prior to enactment that would have required California residents to have minimum essential health care benefits and FTB to distribute a form that provides information about those requirements.

OTHER STATES' INFORMATION

The states surveyed include *Florida, Illinois, Massachusetts, Michigan, Minnesota, and New York.* These states were selected due to their similarities to California's economy, business entity types, and tax laws.

Of these states, only *Massachusetts* has enacted comprehensive health care reform similar to what is proposed by this bill. Key components and dates of the *Massachusetts* legislation are as follows:

- Health Reform is signed into law April 12, 2006.
- Effective July 1, 2007, with some exceptions, adults must have health insurance.
- All employers with 11 or more full-time-equivalent employees must offer a section 125 plan that meets certain standards. Employers who fail to do this may be charged part of the cost when an employee needs state help to pay for urgently needed medical care.

- Effective October 1, 2007, employers with 11 or more full-time-equivalent employees must make a "fair and reasonable" contribution toward an employee health plan or pay a state assessment of up to $295 per employee, per year.
- By December 31, 2007, adults must show that they have enrolled in a health insurance plan or lose their 2007 personal exemption credit.
- By January 1, 2008, penalties increase for adults who do not have insurance to equal half the premium of the lowest-cost Health Connector-certified insurance plan.
- The Health Connector offers subsidized programs for low income individuals and unsubsidized programs for other individuals and small employers.

PROGRAM BACKGROUND

FTB currently collects debts referred from courts of 43 counties and maintains an inventory of approximately 1.1 million cases. In August 2004, legislation was enacted (SB 246, Stats. 2004, Ch. 380) making FTB's Court Ordered Debt (COD) program permanent and requiring FTB to expand participation to all 58 counties and superior courts. To meet this requirement, FTB initiated the Court Ordered Debt Expansion (CODE) Project to develop and implement a scalable collection and billing system. CODE is in development, and the department expects it to be functional by August 2009. CODE is expected to administer an inventory of approximately 8 million cases from potentially 190 different courts.

FISCAL IMPACT

FTB's implementation plans for the collection of health care premiums is contingent on the business requirements the client agency (CHHS) would prescribe to determine both system and program functionality. In addition, it appears that HIPAA requirements, which are not currently incorporated into FTB systems or processes, would apply. Assuming that the business requirements would mirror similar non-tax debt collection programs administered by FTB, one-time system development costs are estimated to be approximately $29.9 million (including 161.5 personnel years) spread over a two-year development schedule. Additional time to secure procurement of resources would be needed to implement this system. Ongoing annual system maintenance costs of approximately $3.4 million (including 35.1 personnel years) would be required to implement this bill. System costs reflect costs developed for implementation of the CODE system, with adjustments made for risk factors associated with the following:

- Concurrent start up of both CHHS and FTB systems,
- Timeline constraints (i.e., implementation is assumed to be required within a relatively short timeframe),
- Unknown business requirements, and
- Unknown HIPAA requirements.

One-time program support—i.e., departmental business area—costs are estimated to be approximately $500,000 and annual ongoing program support costs are estimated to be approximately $5.6 million (including 75 personnel years) would also be incurred. Program costs reflect costs consistent with those required to administer the COD non-tax debt collection

operations. When FTB and CHHS agree upon business requirements, adjustments to these estimates should be made.

It is recommended that the bill be amended to include appropriation language that would provide funding to implement this provision. Lack of an appropriation will require the department to secure the funding through the normal budgetary process, which may further delay implementation of this provision.

ECONOMIC IMPACT

The provision that would require the FTB to collect on health care premium debts would have no impact on general fund revenues with the assumption that tax debts would be given higher priority in collection over health care premium debts. However, to the extent that health care premium debts are given priority in collection, there could be a significant impact on general fund revenues collected by the FTB.

HEALTH SAVINGS ACCOUNT CONFORMITY

EFFECTIVE/OPERATIVE DATE

If enacted during the special session, this bill would be effective on the 91st day after adjournment of that special session, and specifically operative for taxable years beginning on or after January 1, 2010.

ANALYSIS

FEDERAL/STATE LAW

Health Savings Accounts

Under federal law, individuals with a high deductible health plan (HDHP), and no other health plan other than a plan that provides certain permitted coverage, may establish an HSA. In general, HSAs provide tax-favored treatment for current medical expenses as well as the ability to save on a tax-favored basis for future medical expenses. In general, HSAs are tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents.

Within limits, contributions to an HSA made by or on behalf of an eligible individual are deductible by the individual in determining adjusted gross income (AGI) (i.e. “above-the-line”). Contributions to an HSA are excludable from income and employment taxes if made by the employer. Earnings on amounts in HSAs are not taxable. Distributions from an HSA for qualified medical expenses are not includible in gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 10%. The 10% additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).
The maximum aggregate annual contribution that can be made to an HSA is the lesser of

(1) 100% of the annual deductible under the HDHP,[5] or (2) (for 2007) $2,850 in the case of self-only coverage and $5,650 in the case of family coverage.[6] Contributions in excess of the maximum contribution amount are generally subject to a 6% excise tax.

Health Flexible Spending Arrangements and Health Reimbursement Arrangements

Arrangements commonly used by employers to reimburse medical expenses of their employees (and their spouses and dependents) include health flexible spending arrangements (FSAs) and health reimbursement accounts (HRAs). Health FSAs typically are funded on a salary reduction basis, meaning that employees are given the option to reduce current compensation and instead have the compensation used to reimburse the employee for medical expenses. If the health FSA meets certain requirements, then the compensation that is foregone is not includible in gross income or wages and reimbursements for medical care from the health FSA are excludable from gross income and wages. Health FSAs are subject to the general requirements relating to cafeteria plans, including a requirement that a cafeteria plan generally may not provide deferred compensation. This requirement often is referred to as the "use-it-or-lose-it rule."

HRAs operate in a manner similar to health FSAs, in that they are an employer-maintained arrangement that reimburses employees for medical expenses. Some of the rules applicable to HRAs and health FSAs are similar, e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes. Some of the rules are different. For example, HRAs cannot be funded on a salary reduction basis, and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in the next year. Reimbursements for insurance covering medical care expenses are allowable reimbursements under an HRA, but not under a health FSA.

Subject to certain limited exceptions, health FSAs and HRAs constitute other coverage under the HSA rules.

Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-432), enacted December 20, 2006

Starting in 2007, the TRHCA made the following six changes to HSAs:

1. <u>FSA and HRA Terminations to Fund HSAs</u>

   Certain amounts in a health FSA or HRA are allowed to be distributed from the health FSA or HRA and contributed through a direct transfer to an HSA without violating the otherwise applicable requirements for such arrangements. The amount that can be distributed from a health FSA or HRA and contributed to an HSA may not exceed an amount equal to the lesser of (1) the balance in the health FSA or HRA as of September 21, 2006, or (2) the balance in the health FSA or HRA as of the date of the distribution.

[5] The limits are indexed for inflation. For 2006, a high deductible plan is a health plan that has a deductible that is at least $1,050 for self-only coverage or $2,100 for family coverage and that has an out-of-pocket expense limit that is no more than $5,250 in the case of self-only coverage and $10,500 in the case of family coverage.
[6] These amounts are indexed for inflation.

2. Repeal of Annual Deductible Limitation on HSA Contributions

   Limits on the annual deductible contributions that can be made to an HSA are modified so that the maximum deductible contribution is not limited to the annual deductible under the HDHP. Thus, starting in 2007, the maximum aggregate annual contribution that can be made to an HSA is $2,850 (for 2007) in the case of self-only coverage and $5,650 (for 2007) in the case of family coverage.

3. Modification of Cost-of-Living Adjustment

   In the case of adjustments made for any taxable year beginning after 2007, the Consumer Price Index for a calendar year is determined as of the close of the 12-month period ending on March 31 of the calendar year (rather than August 31 as under present law) for the purpose of making cost-of-living adjustments for the HSA dollar amounts that are indexed for inflation (i.e., the contribution limits and the high-deductible health plan requirements).

4. Contribution Limitation Not Reduced for Part-Year Coverage

   In general, starting in 2007, individuals who become covered under a high deductible plan in a month other than January are allowed to make the full deductible HSA contribution for the year rather than, as under prior law, being required to prorate the deduction based on the number of months the individual was enrolled in a HDHP.

5. Exception to Requirement for Employers to Make Comparable HSA Contributions

   Enacts an exception to the comparable contribution requirements to allow employers to make larger HSA contributions for nonhighly compensated employees than for highly compensated employees. For example, an employer is permitted to make a $1,000 contribution to the HSA of each nonhighly compensated employee for a year without making contributions to the HSA of each highly compensated employee.

6. One-Time Distribution from Individual Retirement Plans to Fund HSAs

   Allows a one-time contribution to an HSA of amounts distributed from an individual retirement arrangement (IRA). The contribution must be made in a direct trustee-to-trustee transfer. Amounts distributed from an IRA under these rules are not includible in income to the extent that the distribution would otherwise be includible in income. In addition, such distributions are not subject to the 10% additional tax on early distributions.

Current California Law

California has not conformed to any of the federal HSA provisions. The California personal income tax return starts with federal AGI and requires adjustments to be made for differences between federal and California law. Adjustments relating to HSAs are required under current law, as follows:

- A taxpayer taking an HSA deduction on the federal individual income tax return is required to increase AGI on the taxpayer's California personal income tax return by the amount of the federal deduction.
- Any interest earned on the account is added to AGI on the taxpayer's California return.

- Any contribution to an HSA, including salary reduction contributions made through a cafeteria plan, made on the employee's behalf by their employer is added to AGI on the employee's California return.

Although California has not conformed to HSAs, California law is conformed to the federal rules for Archer medical savings accounts (MSAs) and allows a deduction equal to the amount deducted on the federal return for the same taxable year. California imposes a 10% additional tax rather than the 15% additional federal tax on distributions from an MSA not used for qualified medical expenses.

Because a tax-free rollover from an MSA to an HSA is not allowed under California law, any distribution from an MSA that is rolled into an HSA must be added to AGI on the taxpayer's California return and as that MSA distribution is not treated as being made for qualified medical expenses it would, therefore, be subject to the MSA 10% additional tax.

Additionally, a federal tax-free qualified HSA funding distribution is not allowed under California law because California specifically does not conform to IRC section 223, relating to HSAs, even though California conforms to IRC section 408, relating to IRAs.

Under California law, any distribution from an IRA to an HSA must be added to AGI on the taxpayer's California return and would be subject to a 2½ % additional tax under the rules for premature distributions under IRC section 72.

THIS PROVISION

Starting with taxable year 2010, this provision would conform to the federal HSA provisions as amended by the TRHCA of 2006, as follows:

1. Allows the same deduction by the individual in determining AGI ("above-the-line" deduction) for contributions to an HSA by or on behalf of an individual and adopts the rules applicable to the trust itself in order for the trust to be exempt from tax. In addition, the disqualified distribution penalty applicable to HSAs is modified for California purposes to be 2½ % instead of the federal rate of 10% to be consistent with the other California penalty provisions applicable to IRAs. Consistent with general conformity policy in other areas, the federal 6% excise tax on excess contributions and the federal estate tax provisions are not being conformed to by this bill.

2. Allows the same exclusion from an employee's gross income for the amount of any contributions to an HSA (including salary reduction contributions made through a cafeteria plan) made on the employee's behalf by their employer.

3. Allows rollovers from MSAs to be made to HSAs, as well as rollovers between HSAs, without penalty.

4. Adopts the same $50 penalty for failure to make required reports.[7]

[7] Pursuant to IRC section 223(h), the Secretary of the Treasury may require reports to be filed by an HSA trustee with the secretary and with the account beneficiary regarding account transactions. Reports also may be required to

5. Allows certain amounts in health FSAs or HRAs to be distributed from the health FSA or HRA and contributed through a direct transfer to an HSA without violating the otherwise applicable requirements for such arrangements.

6. Conforms to repeal of annual deductible limitation on HSA contributions.

7. Determines the Consumer Price Index for a calendar year as of the close of the 12-month period ending on March 31 of the calendar year (rather than August 31 as under prior law) for the purpose of making cost-of-living adjustments for the HSA dollar amounts that are indexed for inflation (i.e., the contribution limits and the HDHP requirements).

8. Allows individuals who become covered under a high deductible plan in a month other than January to make the full deductible HSA contribution for the year rather than being required to prorate the deduction based on the number of months the individual was enrolled in an HDHP.

9. Conforms to an exception to the comparable contribution requirements to allow employers to make larger HSA contributions for nonhighly compensated employees than for highly compensated employees. For example, an employer is permitted to make a $1,000 contribution to the HSA of each nonhighly compensated employee for a year without making contributions to the HSA of each highly compensated employee.

10. Allows a one-time contribution to an HSA of amounts distributed from an IRA. The contribution must be made in a direct trustee-to-trustee transfer. Amounts distributed from an IRA under these rules are not includible in income to the extent that the distribution would otherwise be includible in income. In addition, such distributions are not subject to the 2½% additional tax on early distributions.

TECHNICAL CONSIDERATIONS

To achieve the intended HSA conformity for taxable years beginning on or after January 1, 2010, coordination would be required amongst several added or amended sections of the Revenue and Taxation Code (R&TC). The bill uses the incorrect operative date—i.e., January 1, 2009—in two of these impacted R&TC sections. Amendment 1, attached to this analysis, would correct this error.

LEGISLATIVE HISTORY

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the Secretary and account beneficiary by any person who provides an individual with a high deductible health plan. This provision would require the same reports—and penalty for failure to report—for California purposes as required for federal purposes. Thus, any required reports would be filed with FTB in addition to the Secretary and account beneficiaries.

ABX1 4 (Nakanishi, 2007/2008) would provide conformity to the federal HSA provisions identical to this provision except that the conformity would apply starting with tax year 2008. The bill is currently at the Assembly Desk.

ABX1 8 (Villines, 2007/2008) would, in addition to establishing health care related income tax credits for employers and physicians, provide conformity to the federal HSA provisions identical to this provision except that the conformity would apply for tax years beginning on or before January 1, 2008, and before January 1, 2013. This bill is currently in the Assembly Health Committee.

SBX1 10 (Maldonado, 2007/2008) would provide conformity to the federal HSA provisions similar to this provision except that conformity would apply starting with tax year 2006. The bill is currently in the Senate Health Committee.

AB 84 (Nakanishi/Smyth, 2007/2008) is identical to this provision. That bill was held in the Assembly Revenue and Taxation Committee.

AB 142 (Plescia, 2007/2008) and AB 245 (DeVore, 2007/2008) are nearly identical to this provision, except that conformity to the federal HSA provisions would apply starting with taxable year 2007. These bills were held in the Assembly Revenue and Taxation Committee.

SB 25 (Maldonado and Runner, 2007/2008) is nearly identical to this provision except that conformity to the federal HSA provisions would apply starting with tax year 2006 and amended returns would be allowed. That bill was held in the Senate Revenue and Taxation Committee.

SB 1787 (Ackerman, 2005/2006) and SB 1584 (Runner and Ackerman, 2005/2006) would have retroactively conformed to the federal HSA provisions starting with tax year 2004 and would allow amended returns to be filed. Both bills were held in the Senate Revenue and Taxation Committee.

SB 173 (Maldonado, 2005/2006) and AB 661 (Plescia, 2005/2006) were nearly identical to this provision, except that conformity to the federal HSA provisions would apply starting with taxable year 2006. SB 173 was held in the Senate Revenue and Taxation Committee. AB 661 was held in the Assembly Revenue and Taxation Committee.

AB 2010 (Plescia, 2005/2006) was nearly identical to this provision except that conformity to the federal HSA provisions would apply starting with tax year 2007. That bill was held in the Assembly Revenue and Taxation Committee.

AB 2315 (Maldonado/ Nakanishi, 2003/2004), as amended May 17, 2004, was nearly identical to this provision, except that the federal HSA provisions would apply starting with tax year 2006. That bill was held in the Assembly Appropriations Committee.

OTHER STATES' INFORMATION

The states surveyed include *Florida, Illinois, Massachusetts, Michigan, Minnesota,* and *New York.* These states were selected due to their similarities to California's economy, business entity types, and tax laws. *Florida* does not impose a personal income tax so a comparison to Florida is not relevant. *Illinois, Massachusetts, Michigan, Minnesota,* and *New York* conform to the federal deduction for contributions to HSAs.

FISCAL IMPACT

The bill would not significantly impact the department's costs.

ECONOMIC IMPACT

Revenue Estimate

Based on data and assumptions discussed below, this provision would result in the following revenue losses.

Estimated Revenue Impact for ABX1 2 Effective for Taxable Years BOA 1/1/10 ($ in Millions)		
2008-09	2009-10	2010-11
No Impact	− $5	− $46

These estimates reflect only the impact of allowing a deduction for HSAs in conformity with federal law. In the context of the comprehensive health care reform provisions included in this bill, effects of potential interactions and/or taxpayer reactions are uncertain. Additionally, this analysis does not consider the possible changes in employment, personal income, or gross state product that could result from this bill.

Revenue Discussion

The revenue impact of the bill would be determined by (1) the amount of contributions to HSAs deducted on tax returns, (2) the amount of contributions to HSAs made on behalf of employees (including salary reduction contributions), (3) the amount of funds in Archer MSAs rolled over to HSAs, and (4) the result of conforming to the expanded HSA provisions included in the TRHCA of 2006 and marginal tax rates of taxpayers deducting or excluding such contributions.

1. For the 2004 taxable year, tax return data indicates 7,500 returns reflected HSA adjustments on Schedule CA, California Adjustments, totaling $20 million. This means that these taxpayers made tax-deductible contributions for federal purposes that were reversed for state purposes. Recent articles indicate the number of HSAs nationwide doubled during 2005 and again in 2006. To derive the estimates, this substantial growth rate is used through 2007 and is decreased thereafter to more sustainable rates. For 2010, contributions by California individual taxpayers to HSAs are estimated at $365 million. Applying a marginal tax rate of 7% results in a revenue loss of approximately $25.6 million ($365 million x 7% ≈ $25.6 million).
2. Contributions made by an employer on behalf of an employee (including salary reduction contributions made through a cafeteria plan) cannot be identified on a tax return. It is not known how many additional HSAs may exist as a result of this contribution arrangement.

Data indicate that 6% of employers offer HSA-eligible HDHPs. It is believed that most of these employers pay the premium for the HDHP rather than contribute to the employee's HSA. The rationale is that the premium is often less than the amount of the deductible that can be contributed to the HSA. Also, HSA balances are portable and not owned by the employer. For purposes of an estimate, it is assumed that employer contributions on behalf of an employee are approximately one-fourth of that by individuals, or approximately $91 million in 2010 ($365 million x 25% ≈ $91 million). Applying a marginal tax rate of 7% results in an additional revenue loss of approximately $6.4 million for 2010 ($91 million x 7% ≈ $6.4 million).

3. The following is the estimate for the potential rollover of balances in Archer MSAs. For the 2002 taxable year, tax return data indicate deductible MSA contributions totaling $11.6 million reported on 4,600 returns. It is possible that balances in some MSAs have already been rolled over. In addition, there is no requirement that balances must be rolled over. It is assumed that half of these accounts (4,600 x 50% = 2,300) would be rolled over and each account has an average balance of $6,250. This balance equates to two-and-a-half years of average contributions (2.5 years x $2,500 average annual contribution = $6,250). Applying a marginal tax rate of 7% results in an approximate loss of an additional $1 million (2,300 x $6,250 x 7% ≈ $1 million). It's anticipated that rollovers would likely occur in the initial one or two years of conformity. Therefore, the $1 million loss is divided between 2010 and 2011, or $0.5 million each taxable year.
4. For expanded HSA provisions included in the TRHCA of 2006, estimates are based on a proration of federal estimates developed for the act. For these provisions, the conformity estimate is an additional loss of $3 million for the 2010 taxable year.

For taxable year 2010, the estimated loss is $35.5 million ($25.6 million + $6.4 million + $0.5 million + $3 million = $35.5 million). Tax year estimates are converted to the cash flow fiscal year revenue estimates reflected in the table. For example, the 2009-10 revenue loss of $5 million consists of $5 million for the 2010 taxable year. The 2010-11 revenue loss of $46 million consists of $37 million for the 2010 taxable year and $9 million for the 2011 taxable year.

POLICY CONCERNS

This proposal would conform California law to certain federal provisions as amended by indicated federal acts. Conformity to any subsequent changes to those federal provisions would require affirmative action by the Legislature.

LEGISLATIVE INTENT TO ENACT REFUNDABLE INCOME TAX CREDIT

EFFECTIVE/OPERATIVE DATE

If enacted during the special session, this intent language would be effective on the 91st day after adjournment of this special session, but would not apply to any taxable year. However, the provision would specify that it is the intent of the Legislature for the described income tax credit to apply for taxable years beginning on or after January 1, 2010.

ANALYSIS

FEDERAL/STATE LAW

Current federal law allows a refundable credit for health insurance costs of a narrow class of individuals—i.e., trade-displaced workers and certain pension recipients, as described in IRC section 35. An "eligible individual" may claim a refundable health coverage tax credit (HCTC) equal to 65% of his qualifying health insurance costs. Eligibility for the credit is determined on a monthly basis. A month is an eligible coverage month, but not before December, 2002, if as of the first day of that month the taxpayer is an "eligible individual," is covered by qualified health insurance, does not have other specified—generally subsidized—coverage, and is not imprisoned under federal, state, or local authority. The credit cannot be claimed by an individual who may be claimed as a dependent on another person's tax return. IRS must pay the refundable health insurance costs credit in advance. California does not conform to this federal provision.

Existing state and federal laws provide various tax credits designed to provide tax relief for taxpayers who incur certain expenses (e.g., child adoption) or to influence behavior, including business practices and decisions (e.g., research credits or economic development area hiring credits). These credits generally are designed to provide incentives for taxpayers to perform various actions or activities that they may not otherwise undertake.

Current federal law allows self-employed persons to deduct from gross income 100% of amounts paid for health insurance for themselves, spouses, and dependents, under certain circumstances. Individual taxpayers who itemize deductions may use medical expenses that exceed 7.5% of their federal AGI to reduce their taxable income. Unreimbursed insurance premiums paid for health care coverage are included as medical expenses for purposes of this deduction. California law conforms to these provisions.

THIS PROVISION

This provision would state the Legislature's intent to establish an income tax credit to make the cost of health care coverage more affordable for individuals and families not eligible for government-subsidized coverage. This provision would also state the intended structure of the credit as follows:

- The credit would equal the amount of qualified health coverage premiums paid by the taxpayer in excess of 5% of California AGI.
- The amount of qualified health care plan premium costs could not exceed the lesser of the amount of actual qualified premiums paid during the taxable year or the cost of a premium for minimum coverage for unsubsidized health coverage, as determined by the MRMIB.
- Qualified taxpayers would have a California AGI between 250% and 350% of the federal poverty level (FPL), as defined, and could not be eligible to receive employer-sponsored coverage.
- The amount of credit in excess of a taxpayer's personal income tax liability would be refundable.

- A qualified taxpayer would be permitted to apply for an advance of the estimated credit amount (premium credit advance). MRMIB would administer the advance process and would apply such advances to pay health coverage premiums on behalf of an individual, spouse, and dependents.

- Any taxpayer allowed the premium credit advance would be required to file a return and the tax due would be increased by the aggregate amount of advances paid on the taxpayer's behalf.

IMPLEMENTATION CONSIDERATIONS

Stated as Legislative intent, this provision would have no legal effect. As such, FTB could not implement this provision unless this bill is amended to eliminate the intent language or if enabling legislation is enacted. With the assumption that such legislation would be enacted, the department has identified the following implementation concerns. Department staff is available to work with the author's office to resolve these and other concerns that may be identified.

1. This bill does not include language that would make the credit and advance of the credit operative. Statutes describing the authority and responsibilities of MRMIB would need to be modified to include the determination of a "premium for minimum coverage"[8] and the administration of the advance, including a provision to exchange any necessary data with FTB in order for FTB to administer the credit. For example, FTB would need to know the premium amount for minimum coverage and may need to verify the amount of premiums paid to determine the amount of tax credit the taxpayer is entitled to claim. FTB would be able to implement the tax credit only if sufficient data is provided with respect to the amount of premiums actually paid by the taxpayer. Conversely, MRMIB may need tax data to determine the reasonable amount of credit that can be advanced on behalf of a taxpayer for payment of premiums.

2. Because the provision appears to contemplate coordination between FTB and MRMIB with respect to the administration of the credit and credit advances, language would be necessary to allow for exchange of tax data. Specifically, the law would need to provide for an express exception to current disclosure restrictions relating to tax data. Such exception should expressly exclude any federal tax data maintained in FTB's records to preserve and comply with the existing disclosure agreement and requirements related to federal tax data.

3. It is unclear whether departmental processes and systems would be subject to federal HIPAA requirements as a result of receipt of insurance premium data from MRMIB. An affirmative determination could significantly impact the department and, as noted below, substantially increase the department's costs to implement this proposal.

[8] This MRMIB responsibility is stated in proposed R&TC section 17052(b)(4) of this bill.

4. The credit language would not limit the definition of "qualified taxpayer" to those taxpayers that would be subject to the individual mandate and therefore could be claimed by any taxpayer otherwise meeting the criteria.[9] Staff suggests the language be modified to limit qualified taxpayers to individuals subject to the mandate.[10]

5. If it is intended that the credit be verified during initial personal income tax return processing, FTB would need premium data from MRMIB annually and as close to taxable year end as possible to minimize delay in issuing personal income tax refunds. In the alternative, returns claiming the credit prior to receiving data from MRMIB would be held, pending receipt of that information, until FTB has the historical experience to establish a reasonable threshold for allowing refunds during that period.

6. Refundable credits are susceptible to fraud. Resources would be necessary to detect and prevent fraud. Unlike the existing refundable child and dependent care credit, reliable third party information—from MRMIB—would presumably reduce fraud by increasing both detection and prevention. The risk of fraud would substantially increase if MRMIB is unable to provide the data necessary to verify upon initial processing the credits claimed.

7. At least two new lines would need to be added to individual tax returns to allow taxpayers to claim the credit and report any advances received. Instructions would be added and a schedule or worksheet would be created to compute the credit. The addition of two lines may result in a 3-page return, which would increase annual costs as discussed, below, under Fiscal Impact.

8. Consistent with the law as it applies for refundable credits, any corrections to the credit in processing would be treated as a math error adjustment[11] and billed to the taxpayer. Taxpayers wishing to dispute the adjustment would be required to pay the amount owing and file a claim for refund.

9. If MRMIB were to use prior year income tax data to compute advances, this provision may increase FTB's accounts receivable. This may occur because of the disconnect between the prior year tax data on which the advance would be computed and the actual current year tax data upon which the credit would be computed. Additional collection resources may be required if any resulting increase is substantial and requires manual handling.

10. Unless it is modified, fewer taxpayers would be able to use the user-friendly Form 540 2EZ, California Resident Income Tax Return, because it does not require AGI or other information necessary to process the credit.

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[9] Albeit, qualified premiums would be required to be purchased through MRMIB. Presumably, such purchases would only be allowed to those individuals covered by the mandate.

[10] Section 14 of the bill would set forth the individual mandate, which would include "every California resident," as defined.

[11] An adjustment to a tax return balance due that is treated as a math error adjustment pursuant to applicable statutes is due upon notice and demand. A taxpayer may protest or appeal such an adjustment only after the adjustment amount is paid, at which point the taxpayer may file a claim for refund.

11. Currently, only taxpayers with AGI or gross income in excess of certain threshold amounts are required to file income tax returns with the department. The proposed language would require taxpayers who receive a premium credit advance to file a return regardless of income level. This would increase the volume of returns required to be processed annually by FTB than under current law.

12. Individuals included on an income tax return may not match the individuals included in a family for health care coverage purposes. For example, a taxpayer may be required to purchase insurance pursuant to divorce agreement for a family member that is appropriately not included on his or her income tax return, such as a child reported as a dependent on another taxpayer's return. Because FTB would administer this credit based on the individuals included on the return, it is unclear how these issues would be reconciled.[12]

13. FPL appears to be based on family or household size. Similarly, if a taxpayer files a single income tax return with no dependents, without evidence to the contrary, the department would use the FPL for a family of one for determining credit eligibility, even if there are other members of the taxpayer's family or household that are not included on the return.

FISCAL IMPACT

Assuming enabling legislation is enacted—or this provision is amended to remove intent language and resolve implementation concerns described above—it is estimated that the department would incur costs of approximately $1.6 million for first-year implementation and $1 million in ongoing annual operational costs for FTB to implement and administer the refundable credit proposed in this bill.

The proposal would establish a refundable credit that could be advanced for payment of premiums. These features would require the following:

- System changes requiring new programming and testing.
- Processing changes and additional keying requirements, which would include an interface with MRMIB for data to establish the amounts of premiums paid and premiums advanced.
- Limited education and outreach efforts—it is assumed that there would be substantial education and outreach efforts with respect to the broader health care reform program handled by MRMIB or other health care organizations.
- Modifications to forms and instructions.
- Increased customer service inquiries through the call centers in the department.

[12] The individual mandate language of this bill, described in brief earlier in this analysis, would require an subscriber, as defined, to obtain at least minimum health care coverage for any individual who is the subscriber's "dependent" as that term is defined in the IRC as applicable for California income tax purposes. This definition may include unintended individuals. For example, the term "dependent" includes a "qualifying relative." Assuming income and support requirements are met, a nonrelative could be a qualifying relative if that person has the same principal place of abode as the taxpayer and is a member of the taxpayer's household. In addition, a taxpayer's siblings or stepsiblings, parents or stepparents, nieces, nephews, aunts and uncles, in addition to other relations, may also be considered for purposes determining whether an individual is a qualifying relative.

In addition, the department could incur costs to collect increased accounts receivable as a result of this proposal (such as for advances made in excess of the credit allowed), but such costs cannot be estimated because such an increase cannot be quantified. The present forms have limited space available for additional lines. If these changes, along with other pending legislation, increase the forms from two to three pages, the department would incur additional costs for revising the forms and instructions, printing, systems changes, processing, and storage.

Any change to the intended credit proposal could result in substantial changes in cost estimates. In addition, it is unclear whether departmental processes and systems would be subject to federal HIPAA requirements as a result of receipt of insurance premium data from MRMIB. Such requirements could substantially increase the department's costs to implement this proposal.

It is recommended that the provision be amended to include appropriation language that would provide funding to implement this bill. Lack of an appropriation will require the department to secure the funding through the normal budgetary process, which will delay implementation of this provision.

ECONOMIC IMPACT

As noted at the beginning of this analysis, staff understands that the revenue estimates, as well as the other fiscal analyses, for the different aspects of this bill are being developed by Jon Gruber. As such, even though FTB would typically be responsible for developing revenue estimates for changes to personal income and corporation tax law, department staff will not perform these analyses for the premium credit provision in this bill.

LEGAL IMPACT

It appears the intended credit would apply only to California residents, but not nonresidents, as those terms are defined for California income tax purposes. However, some nonresident individuals may nevertheless be subject to the individual mandate. This is because the concept of residency is defined differently for California income tax purposes than it would be for purposes of the individual mandate. The U.S. Supreme Court in *Lunding Et Ux. v. New York Appeals Tribunal et al.* (1998) 522 U.S. 287, found that New York's denial of an alimony deduction to nonresident taxpayers, while allowing such a deduction to resident taxpayers, was discriminatory and thus unconstitutional. Thus, if the intended health coverage premium credit in this provision is conditioned on residency in California, it may be subject to constitutional challenge.

ARGUMENTS/POLICY CONCERNS

1. Employees with employer-subsidized health plans would be ineligible for the credit and, therefore, would not be able to receive the same benefit that similarly-situated taxpayers would receive by purchasing health care coverage through MRMIB.

2. The credit would give a preference for MRMIB plans versus employer-subsidized plans by excluding individuals participating in employer plans from the credit.

3. California AGI may be an inadequate measure of need for assistance to pay for health care coverage. For example, AGI excludes deferred compensation. Also, significant income may be offset by large capital or partnership losses, resulting in a low AGI.

4. This provision lacks a sunset date. Sunset dates generally are provided to allow periodic review of the effectiveness of the credit by the Legislature.

5. Conflicting tax policies come into play when a credit is provided for an item that is already deductible. In this case, unreimbursed or unsubsidized expenditures may be deductible by a taxpayer as an itemized deduction to the extent total medical expenses are in excess of 7.5% of AGI. Such expenses are fully deductible "above-the-line" by self-employed individuals. Providing both a credit and allowing the deduction would have the effect of providing a double benefit for that item or cost. On the other hand, making an adjustment to deny the deduction in order to eliminate the double benefit creates a difference between state and federal taxable income, which is contrary to the state's general federal conformity policy.

125 PLAN MANDATE

EFFECTIVE/OPERATIVE DATE

If enacted during the special session, this bill would be effective on the 91st day after adjournment of this special session, and specifically operative January 1, 2010.

ANALYSIS

FEDERAL/STATE LAW

Current federal law allows employers to extend certain benefits, including health care benefits, to employees without requiring inclusion of such benefits in the gross income of employees. For example, employees can exclude from gross income amounts received from an employer, directly or indirectly, as reimbursement for expenses for the medical care of the employee, the employee's spouse, and the employee's dependents. An employee also excludes from gross income the cost—that is, premiums paid—of employer-provided coverage under an accident or health plan.[13] Insurance premiums paid for partners and more-than-2% S corporation shareholders are not excludable. Highly compensated individuals who benefit from an employer's "self-insured" medical reimbursement plan that discriminates in favor of "highly compensated employees," as those terms are defined, must include in income benefits not available to other participants in the plan.[14]

Under IRC section 125, current federal law allows employers to offer a choice of benefits—assuming such benefits are otherwise excluded from gross income under a specific provision of the IRC—or cash to employees. A plan under IRC section 125 is also known as a "cafeteria plan." It is a written plan under which employee-participants may choose their own "menu" of benefits consisting of cash and "qualified benefits."

[13] IRC § 106.
[14] IRC § 105(h).

No amount is included in the gross income of the employee-participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan. Employer contributions to a cafeteria plan can be made under a salary reduction agreement with the employee-participant if it relates to compensation that hasn't been received by, and does not become currently available to, the participant.

A cafeteria plan can also include "flexible spending accounts" (FSAs) that are funded by employee contributions on a pre-tax salary reduction basis to provide coverage for specified expenses—such as qualified medical expenses or dependent care assistance—that are incurred during the coverage period and may be reimbursed.

IRC section 125 provides special rules with respect to plans that discriminate based on eligibility and benefits in favor of "highly compensated participants" and "key employees."

The practical benefit of cafeteria plans is that employees may make contributions in payment of benefits, such as insurance premiums, on a pre-tax basis. Such contributions reduce the amount of wages that would otherwise be subject to income, social security, and Medicare taxes for both the employee and employer. [15] Federal law does not require employers to establish cafeteria plans and does not mandate the type of benefit choices offered in the plan as long as the benefits are otherwise "qualified" under applicable provisions of the IRC.

Except for the social security and Medicare deductions, California generally conforms to federal law in this area.

THIS PROVISION

This provision would add a new division to the Unemployment Insurance Code (UIC) to require employers with two or more full-time equivalent employees in this state to adopt and maintain a cafeteria plan pursuant to IRC section 125 for the purpose of allowing employees to pay premiums for health care coverage. Penalties in an amount per employee would apply to any employer that failed to meet this requirement. The provision would provide definitions of key terms, such as employer and full-time equivalent employee. EDD would be required to establish rules and regulations to implement this provision.

IMPLEMENTATION CONSIDERATIONS

It appears EDD would be required to administer and enforce the 125 plan mandate because this provision would reside in the UIC and would require EDD to establish rules and regulations to implement this provision. Generally, EDD administers employer-related laws and has an existing reporting and enforcement relationship with businesses in the businesses' capacity as employers. As such, this provision would not impact the department's programs or operations.

FISCAL IMPACT

[15] For federal purposes, under the Federal Insurance Contributions Act (FICA), in addition to withholding for personal income tax, wages are subject to withholding for both social security (also known as OASDI for Old Age, Survivors, and Disability Insurance) and Medicare. For 2007, the social security tax wage base limit is $97,500. The employee tax rate is 6.2%, for a maximum contribution of $6,045. The employee tax rate for Medicare is 1.45%. There is no wage base limit for Medicare tax. Employers are required to pay social security and Medicare tax on wages paid in the same amount of the employee contribution.

This bill would not impact the department's costs.

ECONOMIC IMPACT

As noted at the beginning of this analysis, this bill would cause an increase in the number of employees making contributions for health insurance premiums through section 125 plans. The amount of tax reduction resulting from increased section 125 use depends crucially on the estimated behavioral responses to the provisions of this bill. In fact, the tax reduction amounts are truly secondary to the overall expenditure impacts of this bill. Because the impacts that staff would be estimating are secondary and because the estimate of behavioral responses to the various provisions in this bill are being made elsewhere, it does not seem appropriate or helpful to generate revenue estimates that may or may not be aligned with the assumptions and estimates used to determine the primary impacts of this bill. Furthermore, staff understands that Jon Gruber, who has developed the model to simulate the primary impacts of these proposals, will be developing estimates of these secondary impacts.

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FRANCHISE TAX BOARD'S
PROPOSED AMENDMENTS TO ABX1 2
As Amended November 8, 2007

AMENDMENT 1

On page 115, lines 25 and 32, strikeout "2009," and insert:

2010,

BILL NUMBER: AB 8
VETOED DATE: 10/12/2007

To the Members of the California State Assembly:

I am returning Assembly Bill 8 without my signature.

While I appreciate the Legislature's efforts to reform our broken health care system and applaud the hard work that has gone into AB 8, I cannot sign this bill. AB 8 would put more pressure on an already broken system.

AB 8 does not achieve coverage for all, a critical step needed to reduce health care costs for everyone. Comprehensive reform cannot leave Californians vulnerable to loss or denial of coverage when they need it most. Finally, to be sustainable, comprehensive reform cannot place the majority of the financial burden on any one segment of our economy. Unfortunately, AB 8 falls short on all three accounts.

California needs a financially sustainable health care reform plan that shares responsibility, covers all Californians and keeps our emergency rooms open and operating. I cannot support reform efforts that fall short of these goals and threaten to weaken our already broken system.

Sincerely,

Arnold Schwarzenegger

BILL NUMBER: SB 840
VETOED DATE: 09/22/2006

To the Members of the California State Senate: While I commend Sen. Sheila Kuehl's commitment and dedication to providing health care coverage for all Californians, I must return SB 840 without my signature because I cannot support a government-run health care system. Socialized medicine is not the solution to our state's health care problems. This bill would require an extraordinary redirection of public and private funding by creating a vast new bureaucracy to take over health insurance and medical care for Californians - a serious and expensive mistake. Such a program would cost the state billions and lead to significant new taxes on individuals and businesses, without solving the critical issue of affordability. I won't jeopardize the economy of our state for such a purpose. SB 840 relies on the failed old paradigm of using one source - this time the government - to solve the complex problem of providing medical care for our people. It uses the same one-sided approach tried in SB 2, the employer-mandated coverage measure signed into law before I became governor. I opposed SB 2 because it placed nearly the entire burden on employers, and voters repealed it in 2004. I want to see a new paradigm that addresses affordability, shared responsibility and the promotion of healthy living. Single payer, government-run health care does none of this. Yet it would reduce a person's ability to choose his or her own physician, make people wait longer for treatment and raise the cost of that treatment. With my partners in the Legislature, I look forward in 2007 to working to develop a comprehensive and systemic approach to health care that not only provides affordable medical treatment to people when they are ill, but that strives to make sure people don't get sick in the first place. An approach that supports cost containment and recognizes the shared responsibility of individuals, employers and government. That promotes personal responsibility and builds on existing private and public systems. As part of this comprehensive approach, my administration already has worked hard on the fight against obesity, a leading cause of disease in this country. I signed the landmark Healthy Schools Now Act, which bans junk food and sugar-laden drinks in public schools. Our budget included $18 million to replace that junk food with fresh fruits and vegetables so we can start promoting healthy living choices for our youngsters. Recently I signed AB 2384 (Leno) to make fruits and vegetables more affordable and accessible in low-income communities and AB 2226 (Garcia) to help inform 7th grade students and their parents or guardian(s) of the risk of Type 2 Diabetes. Our efforts to effectively prevent and detect diseases extend far beyond obesity prevention. I recently signed legislation to ensure early detection of hearing loss through newborn hearing screenings (AB 2651- Jones). Since Ive taken office we have expanded newborn health screenings from 33 to 85, dramatically increasing the ability to prevent or detect disease early to keep our children as healthy as possible from the beginning. On the question of access, I've made children's coverage a priority, resulting in nearly a quarter million additional children covered by our Medi-Cal and Healthy Families programs.

Building on an $80 million budget investment to target uninsured children who are eligible, but not enrolled in state health care programs, I signed legislation to eliminate roadblocks to coverage, streamline enrollment for Medi-Cal and Healthy Families and reduce the number of kids that lose coverage due to administrative barriers. (SB 437 Escutia, AB 1948 Montanez, and AB 1851 Coto) And on the question of affordability, I reached agreement with the Legislature to provide discounts on prescription drugs of up to 40 - 60 percent off brand name and generic drugs for our neediest citizens.

But we're not stopping there. I convened a California Health Care Summit in July that for the first time brought together experts on all sides of this issue. At the table with us were representatives from academia, government, business, health care and labor. From that summit and follow-up meetings, there emerged a strong sense of how to proceed on health care reform. Affordability is the key to making our system work for everyone, and affordability is exactly what we are dedicating ourselves to. By implementing a statewide plan advancing health information technology that I called for in a recent executive order, we can shave billions of dollars off healthcare costs in California. By creating the 500 elementary school-based health centers I called for in our Health Summit, medical treatment will be more accessible to our children who need it most and they can avoid costly emergency care. We have made progress toward this goal by enacting legislation (AB 2561 Ridley-Thomas) to support California’s school health centers by increasing cross-agency collaboration, gathering data about services delivered in school health centers throughout the state and providing technical assistance to aid in the development of new and existing school health centers. With the same willingness to compromise that we showed this past legislative session on issues like global warming, I know we can reach our goals. I look forward to working with Sen. Kuehl and other members of the Legislature, as well as the experts who participated in our summit and other stakeholders, to create a healthier California. For these reasons, I am returning SB 840 without my signature.

Sincerely,

Arnold Schwarzenegger